DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445295	A. BUILDING _____ B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON MANOR	3641 MEMORIAL BLVD KINGSPORT, TN 37664

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint survey, #31642 and #32126, was conducted from September 23 through September 25, 2013, at Holston Manor. No deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide an environment that maintains or enhances each resident's dignity. The findings included: Observation on September 24, 2013, at 1:45 p.m., in the 200 hallway, revealed Certified Nursing Assistants (CNAs) #1 and #2 walked into the shower room without knocking first on the door. Continued observation revealed the two CNA's entering Resident A's room without knocking first on the door. Interview with the Licensed Practical Nurse (LPN) #1 on September 24, 2013, at 1:50 p.m., in the 200 hallway nurses station, confirmed the staff entered the shower room and the resident's room	F 241	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 241 1. Staff on the 200 hallway given 1:1 in-service by the Risk Manager regarding Dignity and Respect including knocking on doors in patient care areas. 2. All resident have the potential to be affected by the same deficient practice. 3. Staff will be in-serviced on Dignity and Respect with emphasis on knocking on doors in patient care areas by the Risk Manager and or designee by 10/11/2013. 4. Random observation will be preformed at different times of the day to ensure compliance by the Nursing Supervisors and or designee (3 audits per week x 4 weeks) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11-5-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 without knocking on the door. Interview with the Director of Nursing (DON) on September 24, 2013, at 2:00 p.m., in the DON's office, confirmed the CNA's were to have knocked on the door prior to entering the shower room and the resident's room.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to accommodate the needs of one resident (#180) of thirty-five residents reviewed. The findings included: Resident #180 was admitted to the facility on December 14, 2011, with diagnoses including Multiple Sclerosis, Neurogenic Bladder, and Abnormal Gait. Interview with the resident at the 600 hall nurse's desk on September 24, 2013, at 1:40 p.m., revealed the resident's air conditioner was not working properly. Continued interview revealed the air conditioner had not worked properly since June of this year and the Maintenance Director	F 246	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 246 1. Air Conditioner unit in resident #180 room was changed on 9/24/2013. Resident verbalized comfort with temperature in room after change of unit. 2. All resident have the potential to be affected by the same deficient practice. 3. All AC units in the facility will be checked for proper functioning by the Maintenance Director and/or his designee by 10/11/2013. 4. Random checks on the AC units will be performed to ensure compliance by the Maintenance Director and/or his designee (3 audits per week x 4 weeks). Preventive Maintenance schedule will also be continued on the AC units. Quality Assurance Committee will review results during regularly scheduled to evaluate findings and amend plan as necessary.	11/09/2013

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F 248	Continued From page 2 had been informed several times since then. Observation and interview with the Maintenance Assistant in the resident's room on September 24, 2013, at 2:59 p.m., revealed the temperature in the resident's room was seventy-nine degrees. Interview on September 24, 2013, at 7:43 a.m., with the Maintenance Director, in the facility dining room, confirmed the residents air conditioner had been removed three to four months ago and had not been repaired since that time.	F 246		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 278 1. A correction to the previous assessment was completed on 10/07/2013 on resident #27 showing that resident does have bilateral hand contractures. 2. All residents are at risk for inaccurate coding. All assessments have been reviewed for accuracy. 3. The Interdisciplinary Team will be in-serviced on ensuring the accuracy of the Minimum Data Set by the Director of Nursing and/or designee by 10/11/2013	

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F 278	Continued From page 3 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the failed to ensure the accuracy of a quarterly assessment for contractures for one resident (#27) of thirty-five sampled residents. The findings included: Resident #27 was admitted to the facility on April 3, 2001, with diagnoses including Diabetes, Left Side Hemiplegia, Encephalopathy, Chronic Obstructive Pulmonary Disease, and Intracranial Hemorrhage. Medical record review of the Quarterly Minimum Data Set dated July 1, 2013, revealed the resident had cognitive impairment, required assistance with all activities of daily living, and had no functional limitations in range of motion. Observation on September 24, 2013, at 3:35 p.m., revealed the resident lying in bed. Further observation revealed the resident had contractures of both hands. Interview with Minimum Data Set (MDS) Coordinator #1; in the MDS office, on September 24, 2013, at 3:40 p.m., confirmed both hands were contracted. Continued interview confirmed the quarterly MDS dated July 1, 2013, did not reflect the bilateral hand contractures, and had	F 278	4. Random audits will be competed by the Care Plan Director and or DON to ensure accuracy of of the MDSs. (4 residents weekly x 2, then 2 residents weekly x 2 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013

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F 278	Continued From page 4 been coded incorrectly.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to develop a care plan to address a PICC (peripherally inserted central catheter) line for one resident (#242) of thirty-five residents reviewed.	F 279	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F279 1. Care Plan for resident # 242 was updated to reflect the PICC line plan of care on 9/26/2013. 2. All residents with PICC lines are at risk for the same deficient practice. 3. Care Plan of residents with PICC lines were audited on 9/25/2013 to ensure the Care Plan reflected the plan of care for the PICC line. Licensed Nurses and the Care Plan office were in-serviced on PICC line policy on 9/23/2013. by the Risk Manager.	

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F 279	Continued From page 5 The findings included: Observation and interview on September 23, 2013, at 10:14 a.m., in the resident room with the Assistant Director of Nursing (ADON) revealed resident #242 lying in bed, with a PICC line in place in the left upper extremity. Medical record review of the Temporary Care Plan dated September 13, 2013, revealed no documentation of the PICC line. Interview and medical record review of the care plan on September 25, 2013, at 1:20 p.m., with Minimal Data Set Coordinator (MDS) #1 , in the MDS office, confirmed the facility failed to develop a care plan for the PICC line.	F 279	4. Random audits of Care Plans will be completed by the Care Plan Director and or DON to ensure accuracy of the Care Plan. (3 x weekly x 4 weeks) Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 280 1. Care Plan for resident # 91 corrected on 9/24/2013 to reflect discontinuation of alarm. 2. All residents are at risk for the same deficient practice.	

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to revise a care plan to reflect safety devices for one resident (#91) of thirty-five sampled residents. The findings included: Resident #91 was admitted to the facility with diagnoses including Seizure Disorder, Chronic Obstructive Pulmonary Disease, Hypertension, Muscle Weakness, Diabetes, Aphasia, and Abnormality of Gait. Medical record review of the Minimum Data Set dated August 13, 2013, revealed the resident was cognitively impaired and required assistance with all activities of daily living. Medical record review of the resident's current Care Plan dated August 14, 2013, revealed the resident had been care planned for being "at risk for falls" with interventions including "pressure alarm on bed/wheelchair to remind resident to use call light and alert staff res.(resident) needs assistance." Observation on September 24, 2013, at 1:30 p.m., revealed the resident lying on the bed. Further observation revealed no alarms on bed or wheelchair. Interview with the Director of Nursing (DON), in the DON's office on September 24, 2013, at 3:30	F 280	3. 100% audit of resident care plans will be preformed by Care Plan Director, Risk Manager and or DON to ensure that all accurately reflect any current safety interventions or the discontinuation of any safety interventions by 10/18/2013. 4. Random audits of Care Plans will be completed by the Care Plan Director and or DON to ensure accuracy of the Care Plan. (4 residents weekly x 2 weeks, then 2 residents weekly x 2 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013

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F 280	Continued From page 7 p.m., revealed a physician's order was obtained on February 3, 2013, to discontinue the pressure alarms for the bed and wheelchair. Further interview confirmed the resident's care plan had not been revised to reflect the physician's order.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to address the care area of hospice on the interim care plan for one resident (#230), out of thirty-five residents reviewed. The findings included: Resident # 230 was admitted to the facility on June 28, 2013, with diagnoses of Malignant Lung Cancer, Malaise and Fatigue, Chronic Heart Failure, Atrial Fibrillation, Rehabilitation Process, Lack of Coordination, Abnormality of Gait, Anxiety State, and Psychosis. Medical record review of a physician's order dated June 28, 2013, revealed an order for hospice. Medical record review of the resident's interim care plan, revealed hospice care had not been addressed. Interview with the Director of Nursing (DON), on September 25, 2013, at 8:05 a.m., in the	F 281	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F281 1. Care Plan for resident # 230 was not able to be corrected due to the fact that this was a closed chart. Nursing Supervisors and Care Plan Coordinators were in-serviced on ensuring hospice is addressed on the interim care plan on 9/25/2013. 2. All residents with hospice orders are at risk for the same deficient practice. 3. 100% audit of resident care plans for residents with hospice orders was completed on 10/4/2013 by the DON to ensure hospice is addressed on the plan of care. 4. Random audits for Interim Care Plans will be completed by the Care Plan Director and or DON to ensure accuracy related to hospice orders. (3 x weekly x 4 weeks). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013

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F 281	Continued From page 8 conference room, confirmed hospice care had not been addressed on the interim care plan.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to provide services for the care of a resident's PICC line (peripherally inserted central catheter) for one resident (# 242), of thirty-five residents reviewed. The findings included: Observation on September 23, 2013, at 10:14 a.m., in the resident room, with the Assistant Director of Nursing (ADON) revealed the resident in the bed with a PICC (peripherally inserted central catheter) line inserted in the left upper extremity. Continued observation revealed the dressing around the PICC line was dated September 12, 2013. Medical record review with the ADON on September 23, 2013, at 11:02 a.m., at the 600 hall nurse's desk, confirmed there were no orders for the PICC line care and maintenance.	F 309	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 309 1. On 9/23/2013 Nurse Practitioner was contacted and orders to follow facility PICC line Policy were received for resident # 242. ADON completed dressing change for resident # 242 PICC line on 9/23/2013. 2. All residents with PICC lines are at risk for the same deficient practice. 3. 100% compliance in-service provided by Risk Manager to Licensed Nurses regarding PICC line Policy on 9/23/2013. Nursing Supervisor completed 100% audit of residents in facility with PICC lines to ensure orders present and dressing changes were current completed by 9/25/2013.	

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F 309	Continued From page 9 Record review of the facility policy and procedure for PICC line care revealed "...perform dressing change every 7 days or earlier..." Interview with the resident on September 23, 2013, at 11:14 a.m., in the resident's room, revealed the nurses had been flushing the PICC line. Interview with the Director of Nursing (DON) on September 23, 2013, at 2:50 p.m., in the facility conference room, confirmed there were no orders for PICC line care and maintenance. Interview with the Director of Nursing (DON) in the facility conference room, on September 23, 2013, at 3:04 p.m., confirmed the facility policy was not followed for a PICC line dressing change.	F 309	4. Random chart audits will be completed by ADON and or DON to ensure that PICC line Policy is being followed (4 x weekly x 2 weeks, 3 x weekly x 1 week, 2 x weekly x 1 week). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013
F 325 SS=G	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure one	F 325		

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F 325	Continued From page 10 resident (#228) received the required nutrition to maintain an acceptable body weight of thirty-five residents reviewed. The facility's failure resulted in harm to resident # 228. The findings included: Resident #228 was admitted to the facility on August 9, 2013, with diagnoses including Subdural Hematoma (SDH) requiring emergency surgery, Encephalopathy, and Seizures. Medical record review of the admission History and Physical (H&P) on August 13, 2013, revealed the resident had fallen at home in August 2013 and sustained a SDH. Review of the H&P revealed "...is high risk for aspiration and pneumonia with cloudy sensorium." Medical record review of the Minimum Data Sets (MDS) dated August 16 and 23, 2013, revealed a Brief Mental Status score of 11, indicating moderate cognitive impairment, and was total dependence on staff for assistance with eating and drinking. Medical record review of the speech therapist Discharge Report dated September 7, 2013, revealed, "Patient is tolerating current diet of puree/thin liquids well with no overt signs or symptoms of distress...Patient is to remain on puree at this time due to optimal safety...Patient scored a 172/200 at this time indicating a mild dysphagia and aspiration risk on puree/thin consistency." Observation on September 23, 2013, at 12:45	F 325	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 325 1. On 9/24/2013 Nursing received the dietary recommendations dated 9/11/2013 for resident #228 and reviewed them and weight loss with the Nurse Practitioner. The order for Marinol 2.5 mg PO AC lunch and dinner was added to resident's plan of care. THe residents overall condition included weight loss was reviewed with the physician as well and no new orders received. Resident's Kardex and care plan reviewed and were noted to be incorrect regarding resident's ability to feed self. Theses were corrected to accurately reflect resident's ability and desire to feed self. Resident interview shows that resident does not like a pureed diet. Speech was informed and has since picked resident up on caseload with positive results as evidenced by resident now swallowing mech soft biscuit and gravy, scrambled eggs at breakfast as noted per ST note dated 10/28/2013.	

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	445295	A. BUILDING _____ B. WING _____	09/25/2013

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F 325	Continued From page 11 p.m., in resident #228's room revealed the resident remained upright in bed, had a three compartment plate of pureed food on the lunch tray, with soupy pureed beans in one section of the plate. Continued observation revealed the resident ate several bites of creamed potatoes, but none of the pureed beans. Continued observation revealed a carton of whole milk, a green-colored pudding, and a "Magic Cup" (frozen protein supplement) were included on the tray. Observation revealed a family member seated at the resident's bedside. During observation, the family member volunteered... visited "several times each week" and stated "understand (the resident) supposed to be helped when eating...I've never seen anyone help...won't eat those (referring to the Magic Cup)...". Continued observation revealed no facility staff in the room offering assistance to the resident. Review of the Food Intake Record for September 23, 2013, revealed the resident took 25% of the observed lunch. Review of the resident's August and September 2013 Vital Signs and Weight Record revealed the following: August 9 - 156 pounds (on admission); August 10 - 154 pounds; August 17 - 145 pounds (a 7% weight loss); September 15 - 140 pounds (a10.2% weight loss); and September 22 - 140 pounds. Review of the Nurse Practitioner's Resident Encounter Sheet dated August 23, 2013, revealed "...Abnormal Physical Exam Findings: eats 25% maybe of meals. Has lost 11 pounds in 8 days...will add House supplements and Eldertonic" (a liquid supplement used to promote appetite).	F 325	2. Dietary recommendations for all residents revised to ensure no repeat issues. 3. Dietary recommendations will be brought to the clinical portion of the morning meeting to be reviewed by the Interdisciplinary Team. 100% audit of resident Kardexs for accurate coding will be completed by Nursing Supervisors by 10/11/2013. Physician spoke with resident's contact person on 9/26/2013 regarding resident's health status and weight loss. A care plan meeting to include resident, contact person and physician is scheduled for 10/15/2013. 4. Random chart audits will be completed by ADON and or DON to ensure that dietary recommendations have been reviewed with Nurse Practitioner or Physician timely and to ensure that care pans accurately reflect resident's ability to feed self. (4 weekly x 2 weeks, 3 weekly x 1 week, 2 weekly x 1 week). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amend plan as necessary.	11/09/2013

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F 325	Continued From page 12 Review of the Care Plan dated August 15, 2013, revealed the problems of "Alteration in Nutrition...Unable to feed self." Review of the care plan revealed a goal was set for "Adequate Nutritional Intake and No Significant Weight Changes." Continued review revealed the approaches to address the problems included "...Dietician to evaluate and offer intervention; encourage resident to consume 75-100% of each meal...offer substitutes if resident refuses food items...feed resident at all times..." Continued review of the care plan revealed a new problem was added by the Dietary Manager on August 26, 2013, "sig wt (significant weight) changes/unable to feed self." Medical record review of the Dietary Progress Notes dated August 26, 2013, revealed "...DON (Director of Nurses) informed on August 23, 2013, of resident's weight loss...Staff documents some self feeding and at other times resident requiring feeding assistance...Magic Cup added to meal tray at lunch and supper..." Record review of the Nutritional Assessment Recommendations dated September 11, 2013, revealed "...continued weight loss...d/c (discontinue) eldertonic...begin Marinol (a drug used to stimulate appetite) 25 mg BID (twice a day)...request prealbumin (a lab test to help evaluate nutritional status)..." Review of the Food Intake Record revealed from September 1, 2013, through September 21, 2013, the resident had refused twenty meals, breakfast five times, lunch five times, and supper 10 times with an average meal intake of 30% intake.	F 325		

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F 325	Continued From page 13 Record review of the Daily Skilled Nurses Notes for the same period, from September 1-21, 2013, did not reflect the resident was offered an alternative when a meat was refused. Interview and review of the resident's kardex with the Nurse Supervisor at the 400-500 hall nursing station at 8:40 a.m., on September 24, 2013, revealed the kardex indicated the resident was a "feed." Interview continued and the Nurse Supervisor confirmed the resident's bedside nursing staff could refer to the kardex to know how to assist the resident at meals. Interview with the Registered Dietician (RD) on September 24, 2013, at 9:00 a.m., at the 400-500 hall nursing station, verified the RD meets with the Dietary Manager during weekly meetings each Wednesday and reviewed residents with weight loss. Interview revealed "sometimes someone from nursing is there...we don't have an official group that meets to address weight loss." Interview with the Dietary Manager on September 24, 2013, at 1:40 p.m., at the 400-500 hall nursing station, comfirmed the resident had been reviewed for continued weight loss during the August 26-, 2013, and September 11, 2013, meetings with the RD. Continued interview revealed the resident's physician orders were reviewed, and the Dietary Manager confirmed the recommendations given to the Nurse Supervisor to stop Eldertonic and begin Marinol and to obtain a pre-albumin, had not been ordered by the physician. Interview confirmed the resident was now below the ideal body weight by eight pounds. Interview confirmed the Dietary Manager had continued to request the resident be fed as	F 325		

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F 325	Continued From page 14 restated on the August 26, 2013, Care Plan update, "sig (significant) wt (weight) changes, unable to feed self" Continued interview revealed the Dietary Manager was not aware the resident did not like the "Magic Cups" that were being sent with each lunch and supper tray. Interview with the Nurse Supervisor at 2:30 p.m., on September 24, 2013, in the conference room, confirmed the Nurse Supervisor was "unsure" of what happened to the dietary recommendations received from the Dietary Manager and RD. Continued interview revealed the Nurse Supervisor was responsible to convey the recommendations to the physician or the nurse practitioners. Further interview confirmed the nursing staff had not been following the Care Plan to feed the resident and had been setting up the tray in the room to feed self. Interview and review with the Nurse Supervisor at 3:30 p.m., on September 24, 2013, in the conference room, of the Food Intake Record for August 2013, and September 2013, confirmed the following: from August 22 to the present time, the nursing staff had not been following the care plan to feed the resident as documented on the Daily Skilled Nurse's Notes, the resident had meal trays set-up in the resident's room; the resident had refused more meals in September than August; and the resident had consumed less of all meals, especially the breakfast meal in September. Interview continued and the Nurse Supervisor confirmed the licensed nursing staff had not reviewed the way the resident was currently receiving meals with the Certified Nurse Aides (CNA's), the Dietary Manager, or the Speech	F 325		

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F 325	Continued From page 15 Therapist. Interview on September 25, 2013, at 10:40 a.m., in the foyer area adjacent to the main dining room, with the Nurse Practitioner (NP) confirmed the dietary recommendations submitted to the nursing staff by the RD and the Dietary Manager on September 11, 2013, were not received by the NP and no orders were written to change the appetite stimulant Eldertonic to Marinol or for a laboratory test to measure the resident's pre-albumin. Interview with the Medical Director and the DON at 12:45 p.m., on September 25, 2013, in the Medical Director's office, revealed the physician had not seen the resident since the initial admission evaluation on August 10, 2013. Interview verified the physician had not been notified of the resident's weight loss or the RD's recommendations. Continued interview confirmed the professional nursing staff had not met as a group to discuss the resident's weight loss, and nursing had not met with the family, the Dietary Manager, the RD, or the Speech Therapist to address the resident's continued weight loss.	F 325		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		

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F 356	Continued From page 16 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post accurate nurse staffing information as required. The findings included: Observation on September 23, 2013, at 11:20 a.m., in the conference room, revealed the staffing information posted did not accurately reflect the nursing staff on duty for the current day. Observation of the posted staffing revealed, the staffing information was posted before call-ins	F 356	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 356 1. The posted staffing information was corrected on 9/23/2013 to reflect the call in that occurred for the 7-3 shift for Licensed Nurses. 2. All residents are at risk for the same deficient practice. 3. Staffing Coordinator was in-serviced by DON on 9/23/2013 that the posted staffing information must be accurate and reflects any and all changes that occur though out the day. In-service regarding the changing the posted staffing information will be provided to the Licensed Nursing staff by the DON and will be completed by 10/11/2013. 4. Random audits will be completed by ADON and or DON to ensure that the posted staffing information is correct and reflects changes. (4 x weekly x 2 weeks, 3 x weekly x 1 week, 2 x weekly x 1 week). Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and plan as necessary.	11/09/2013

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F 356	Continued From page 17 by Licensed Practical Nurses, and had not been updated to reflect current nursing staff in the facility. Interview with the Director of Nursing at the time of the observation on September 23, 2013, in the conference room, confirmed the staffing information did not reflect the current nursing staff present; and confirmed the facility failed to post accurate staffing.	F 356		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact exist. This Plan of Correction if filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care. F 520 1. The issue of the physician attending QA meeting was discussed by the facility in May 2013 QA meeting and it was decided that one of the Nurse Practitioners will attend the monthly QA meeting as the physician's representative. 2. All residents are at risk for the same deficient practice.	

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F 520	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on review of facility Quality Assessment and Assurance (QAA) sign in sheets, and interview, the facility failed to ensure the required sign-in of the designated physician at the monthly QAA meetings for seven of nine monthly meetings to meet the regulatory quarterly requirements. The findings included: Review of the facility's monthly QAA sign in sheets for the past nine months, revealed the designated physician had not signed the facility's sign-in sheet on the following dates: September 20, 2012, October 30, 2012, November 30, 2012, January 31, 2013, February (no date), 2013, May 29, 2013 (meeting for March and April), and June 28, 2013. Interview on September 25, 2013, at 1:30 p.m., with the Director of Nursing (DON), in the DON's office, revealed the facility meets on a monthly basis for the QAA. Further interview with the DON confirmed the designated physician was not present for the QAA meetings and failed to meet the regulatory quarterly requirements.	F 520	3. A Nurse Practitioner has been present for monthly QA meetings since the facility plan in place in June 2013 as evidenced by the sign in sheets. 4. Administrator will review monthly QA meeting sign in sheets to ensure that either the physician or the Nurse Practitioner were present for the meeting. Quality Assurance Committee will review results during regularly scheduled meetings to evaluate findings and amends plan as necessary MD will continue to attend Quality Assurance meeting quarterly.	11/09/2013